AMENDED IN SENATE APRIL 9, 2013

SENATE BILL No. 746

Introduced by Senator Leno

February 22, 2013

An act to amend Section 1385.04 of the Health and Safety Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 746, as amended, Leno. Health care coverage: premium rates.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law requires health care service plans, for large group plan contracts, at least 60 days in advance of a rate change, to file with the department all specified rate information for unreasonable rate increases and, with that filing, to disclose specified aggregate data.

This bill would instead require the plans to file all specified rate information for rate increases that exceed the Consumer Price Index as published by the United States Bureau of Labor Statistics. The bill would also require a health plan that exclusively contracts with no more than 2 medical groups in the state to disclose *certain information to the department, including the plan's overall annual medical trend factor assumptions by major service category and* the amount of its actual trend experience for the prior contract year by aggregate benefit category, ~~using benefit categories that are, to the maximum extent possible, the same or similar to those used for the individual and small group markets as well as those used by that plan for the individual and small group markets~~ *as specified, and to provide claims or other data*

to large group purchasers that demonstrate the ability to comply with privacy laws, as specified. The bill would require the department, if it determines that a proposed rate is unreasonable, to inform the California Health Benefit Exchange of its determination.

Because a willful violation of the bill's requirements would be a crime, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1385.04 of the Health and Safety Code is amended to read:

1385.04. (a) For large group health care service plan contracts, all health plans shall file with the department at least 60 days prior to implementing any rate change all required rate information for *any* rate ~~increases that exceed~~ *increase that exceeds* the Consumer Price Index as published by the United States Bureau of Labor Statistics. This filing shall be concurrent with the written notice described in subdivision (a) of Section 1374.21.

(b) For large group rate filings, health plans shall submit all information that is required by PPACA. A plan shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.

(c) A health care service plan subject to subdivision (a) shall also disclose the following aggregate data for all rate filings ~~submitted under this section~~ in the large group health plan market:

(1) Number and percentage of rate filings reviewed by the following:

(A) Plan year.

(B) Segment type.

(C) Product type.

(D) Number of subscribers.

(E) Number of covered lives affected.

(2) The plan's average rate increase by the following categories:

(A) Plan year.
(B) Segment type.
(C) Product type.
(3) Any cost containment and quality improvement efforts since the plan's last rate filing for the same category of health benefit plan. To the extent possible, the plan shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.
~~(4)~~
(d) A health care service plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall disclose ~~both~~ *all* of the following:
(1) The plan's overall annual medical trend factor assumptions in the aggregate for large group rates by major service category, including all of the following:
(A) Hospital inpatient.
(B) Outpatient visits.
(C) Outpatient surgical or other procedures.
(D) Professional medical.
(E) Mental health.
(F) Substance abuse.
(G) Skilled nursing facility, if covered.
(H) Prescription drugs.
(I) Other ancillary services.
(J) Laboratory.
(K) Radiology or imaging.
(2) A plan may provide aggregated additional data that demonstrates or reasonably estimates year-to-year cost increases in specific service categories in major geographic regions of the state.
~~(A)~~
(3) The amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used for the individual and small group markets.
(4) The amount of the projected aggregate trend in the large group market attributable to the use of services, price inflation, or fees and risk for annual plan contract trends by major service

category, including hospital inpatient, hospital outpatient, physician services, prescription drugs, other ancillary services, laboratory, and radiology.

~~(B)~~

(5) The amount of its actual trend experience *in the aggregate* for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those ~~used by it for the individual and small group markets.~~ *in paragraph (1).*

(6) The amount of projected trend attributable to the following categories:

(A) Use of services by service and disease category.

(B) Price changes in physician costs, including compensation.

(C) Price changes in hospital contracts.

(D) Price changes in other provider contracts.

(E) Price changes in supplier contracts.

(F) Cost changes in administrative costs for the health plan.

(G) Cost changes in administrative costs for each contracting medical group.

(H) Capital investment for care locations, including, but not limited to, hospitals and medical office buildings.

(I) Other capital investments.

(J) Community benefit expenditures, excluding bad debt and valued at cost.

(K) All other budgetary expenditures, with additional detail as may be required by the department.

(7) The amount and proportion of costs attributed to the medical groups that would not have been attributable as medical losses if incurred by the health plan rather than the medical group.

(e) If the department determines that a proposed rate is unreasonable, it shall inform the California Health Benefit Exchange of its determination. The Exchange shall use this information in the same manner as other information on unreasonable rates.

(f) (1) A health care service plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall provide claims data at no charge to a large group purchaser if the large group purchaser requests the information and if the large

group demonstrates that it is able to comply with relevant state and federal privacy laws.

(2) If claims data is not available, the plan shall provide data sufficient for the large group purchaser to calculate the cost of obtaining similar services from other health plans and evaluate cost-effectiveness by service and disease category. In the absence of claims data, the data shall include patient-level data on demographics, prescribing, encounter, inpatient services, outpatient services, and any other data as may be required of the health plan to comply with risk adjustment, reinsurance, or risk corridors as required by the PPACA. In the absence of claims data, the plan shall provide patient-level utilization data used to experience rate the large group, including diagnostic and procedure coding and costs assigned to each service.

~~(d)~~

(g) The department may require all health care service plans to submit all rate filings to the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing (SERFF). Submission of the required rate filings to SERFF shall be deemed to be filing with the department for purposes of compliance with this section.

SEC. 2. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O